

Mental Health Services Act Accountability

Measuring Specific Outcomes and Performance

Information for the June 23, 2005 Stakeholder Meeting & June 7, 2005 Conference Call

Accountability



One component of accountability is the effectiveness of services, supports and activities as measured by *individual client outcomes and community impact*. The other component is the demonstration that the mental health system is *performing appropriately* in providing services, supports, and activities - that is, *doing what it said it would do*. These two components can be thought of as the two “arms of accountability” that will hold the MHSA transformational processes up to the light, and demonstrate that the mental health system is reaching out to both individuals and the community in ways that produce positive results.

MHSA performance will be measured on three levels, (1) the individual client level, (2) the mental health program/system accountability level, and (3) the public/community-impact level.¹ The focus of the stakeholder workgroup meeting for **June 23, 2005** will be on:

1. Prioritizing outcomes and measurement areas
2. Mapping desired client/community outcome indicators and mental health system performance indicators to the three levels (above)
3. Describing potential methods of measurement

The results of the workgroup will be used as recommendations to the Performance Measurement Committee and the Department of Mental Health, for development of the statewide performance measurement system for the MHSA (and beyond).

Please consider recommending someone or yourself to be a member of the Performance Measurement Committee. A description of the committee and nomination form are included as part of this document as Attachment 1. Committee information and nomination forms are also available on the DMH Mental Health Services Act website at www.dmh.ca.gov/MHSA/default.asp.

Outcomes & Performance Indicators

The Program and Expenditure Plan Requirements document for the Mental Health Services Act--Community Services and Supports stipulates that County proposals will be evaluated for their contribution to meeting specific outcomes for the individuals served including:

¹ Please see the document under separate cover, Preliminary Discussion of the Performance Measurement Design for the MHSA, which details this approach.

<ul style="list-style-type: none"> ▪ Meaningful use of time and capabilities, including things such as employment, vocational training, education, and social and community activities ▪ Safe and adequate housing, including safe living environments with family for children and youth; reduction in homelessness ▪ A network of supportive relationships ▪ Timely access to needed help, including times of crisis ▪ Reduction in incarceration in jails and juvenile halls ▪ Reduction in involuntary services, reduction in institutionalization, and reduction in out of home placements.
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Also, specific outcome and performance areas (some of which overlap with those listed above) have been identified by recent and previous stakeholder input processes:

▪ Recovery and wellness	▪ Substance use
▪ Housing	▪ Quality of life
▪ Criminal and/or juvenile justice system involvement	▪ Illness self-management
▪ Employment/education	▪ Social/community connectedness
▪ Hospitalization (acute/long term restrictive levels of care)	▪ Individualized service plan goals
▪ Income/entitlements	▪ Physical health
▪ Family preservation	▪ Out-of-home placement
▪ Symptoms/suffering	▪ Non-public school placement
▪ Suicide	▪ Graduation rates for children/youth diagnosed with serious emotional disorders
▪ Functioning	▪ Child welfare status

Our first goal is to prioritize the outcome and performance areas. Although the decisions may be difficult to make, DMH would like recommendations with respect to which outcomes and performance areas are most critical and should be addressed first, and which might not be quite as high a priority to measure immediately.

Our second goal is to take these outcome and performance areas and make suggestions for the level(s) at which they should be measured, that is, (1) at the individual client level, (2) the program/system accountability level, or the (3) community impact level. More than one level may apply for some of the outcome and performance areas listed. Please see Attachment 2 for the diagram that depicts the tri-level performance measurement paradigm.

Our third goal is to identify and recommend how the outcome and performance areas might be measured at the level(s) selected. There are a number of general ways in which these issues can be measured: (They are explained in more detail below.)

- Client and services information (electronic record) systems
- Key event tracking methods
- Surveys (including standardized clinical measures)
- Chart /process reviews
- Special studies (e.g., interviews, focus groups, tailored assessments)
- Linking to external databases²

◆ Client and services information (electronic record) systems

These are locally based, electronic service encounter systems that track characteristics of services provided, as well as client information, such as demographics and periodic changes, (e.g., living situation, type of employment). These systems can be thought of as precursors to electronic mental health record systems, in that they provide information on service utilization and some process/outcomes information. As an example of the types of areas that might be measured in client/services information systems, a list of data fields of the current Client and Services Information System is provided as Attachment 3.

◆ Key Event Tracking

The performance indicators and measurement methods of the AB2034 program have been successful in demonstrating the effectiveness of services/supports on positive client outcomes. This type of methodology and reporting is at the heart of the Mental Health Services Act (MHSA) spirit of accountability. Therefore, the tracking of key events that are objective indicators of quality of life (e.g., decreases in homelessness, hospitalization, incarceration, etc.) will be part of the individual client outcomes measurement process with respect to MHSA services/supports delivery. An example of the AB2034 program key event tracking method is provided as Attachment 4.

◆ Surveys

Subjective measurement of issues, such as recovery, wellness, functioning, satisfaction, and evaluation are best measured from the perspective of the individual. The individual may be a client, caregiver, significant other, staff or

² These do not reflect an exhaustive list of ways to measure outcomes and performance, and each has benefits and limitations depending on the particular area of measurement.

other resource person(s) depending on the nature of the information needed. Surveys are typically a successful means of eliciting this type of information. Surveys often have standard formats. (A sample of the consumer perception surveys currently used for services evaluation is provided as Attachment 5.) Also, standard instruments or clinical tools that have good psychometric properties (e.g., reliability and validity) are often appropriate for measuring constructs, such as depression or child functioning. Such measures are typically somewhat lengthy, proprietary, and costly, but may still be an appropriate choice with respect to some outcome or performance areas.

◆ Chart /process reviews

This type of measurement is typically used for evaluation of whether or not services and supports are being provided with fidelity, and in accordance with original statements of intent, design, plan, and promise. Oversight and monitoring through chart review and observation/evaluation of administrative and clinical processes is most often performed in order to yield program/system level accountability information.

◆ Special studies (e.g., interviews, focus groups, tailored assessments)

Special studies may be used when the type of information desired is not needed on an ongoing basis, but rather, when a specific question may need to be answered in the short term. A special study may also be appropriate when general evaluation approaches yield information that points to the need for a more focused assessment.

◆ Linking to external databases

Some information that is needed to address questions of importance to mental health, e.g., criminal justice system, social services, health information, etc., is collected by other systems and agencies. If information is reliably collected in other information systems, it may be possible to link it to information collected in mental health in order to answer broad questions about mental health services impact.

Please also consider the need for comparisons

In most cases, it will be necessary to determine change and progress. Measurement methods will need to be designed that compare data over time and across other variables of interest.

Feedback Forms:

There are two forms to be completed. They are Attachments 6 and 7 of this document. The first form, Prioritization and Mapping of Outcome and Performance Areas, is for prioritization of outcome and performance areas, and mapping those areas to the performance measurement levels of the tri-level paradigm (Attachment 1). At the stakeholder workgroup meeting, stakeholders will be

divided into four groups who will prioritize outcome and performance areas for (1) children/youth, (2) transition age youth, (3) adults, or (4) older adults. A separate form will be completed by each of the four groups. It is likely that the prioritization of outcome and performance areas will be different as they relate to different age groups. Stakeholders may also offer outcome and performance areas that are not on the lists provided.

The stakeholder workgroups will then be asked to map those outcome and performance measurement areas to the level(s) of measurement from tri-level diagram and mark the level on the form.

For the second form, Methods of Measurement, stakeholder groups will be asked to (1) choose at least five outcome or performance areas from the first form, (2) recommend type(s) of measurement (e.g., survey, chart review, key event tracking, etc), (3) provide a short definition or description of the measure, and (4) recommend how often the measurement should take place.

PERFORMANCE MEASUREMENT COMMITTEE NOMINATIONS

The MHSA Performance Measurement Committee

Performance measurement systems are typically developed for the purpose of answering legislative mandates for performance-based accountability. This is true for the Mental Health Services Act (MHSA) performance measurement processes as well. Accountability is one reason to measure performance; other reasons include working toward improving quality and aligning management and administrative practices with quality services, productivity and positive outcomes.

Designing performance measurement systems is a highly complex endeavor that requires numerous decisions about technical issues, such as selection of indicators, assessment tools and other protocols for data collection, as well as information systems/software design and development for data collection, management, analyses and reporting.

The California Department of Mental Health is creating a committee to provide recommendations and input as it develops a comprehensive performance measurement system. This committee is being initiated in response to MHSA performance measurement needs, but will also meet the requirements for a Performance Outcome Committee referenced in Realignment Legislation [Welfare and Institutions Code 5611(a)]. The purpose of this Performance Measurement Committee (PMC) is to inform the performance measurement design, development and implementation for the Mental Health Services Act, and to integrate MHSA performance measurement processes into an overall performance measurement system for mental health system accountability. Responsibilities of the PMC will include:

1. Review of the Mental Health Services Act performance measurement requirements and stakeholder input with regard to performance indicators and outcomes specifically pertinent to the transformational, recovery and wellness missions of the MHSA.
2. Review of quality strategies and frameworks as they inform indicator selection and development, e.g., Institute of Medicine Indicators, The President's New Freedom Commission Report, Quality Chasm Series, etc.
3. Review of performance indicators stipulated in State regulation/national initiatives, and integrate them with MHSA indicators for state and system-wide accountability demonstration (e.g., Realignment Legislation, Decision Support 2000+, and/or Mental Health Statistic Improvement Program domains, etc).
4. Review of indicators currently in State and local use for other accountability and quality improvement needs (Federal Uniform Reporting System requirements, Realignment Legislation mandates, Medi-Cal and HIPAA requirements); Adaptation and reconciliation of these

indicators/measurement approaches where applicable to minimize duplication of data collection efforts.

5. Consolidation of 1 through 4, above in order to inform development of an appropriate set of performance indicators for the MHSA and statewide accountability.
6. Review information technology options that are able to support the various types of information capture necessary to adequately measure the performance indicators of interest.
7. Recommend appropriate methods of measuring performance indicators; determine data capture feasibility and potential level of quality of resulting data for accountability and decision support purposes.
8. Determine and recommend measurement strategies that maximize data collection efficiency and usefulness of resulting data for multiple purposes and multiple stakeholders.

Composition of the Performance Measurement Committee

DMH's goal is to form a diverse committee with relatively equal representation of the regions of California and the specific skills and areas of expertise listed below:

1. Consumer perspective
2. Family member perspective
3. Small County perspective/expertise
4. Large County perspective/expertise
5. Rural County perspective/expertise
6. Urban County perspective/expertise
7. Child /Youth perspective/expertise
8. Transition-Age Youth perspective/expertise
9. Adult perspective/expertise
10. Older Adult perspective/expertise
11. Research /Evaluation/measurement expertise
12. Cultural competence expertise
13. Mental health management/supervisory experience
14. Expertise in Recovery/Wellness philosophy/orientation
15. Mental health services delivery / clinical experience

It is expected that the committee will include providers of mental health services/supports, consumers, family members, measurement experts, and representatives from counties, the California Mental Health Directors Association, the California Mental Health Planning Council, etc.

Potential nominees are encouraged to consider the time commitment and workload associated with committee membership. It is anticipated that monthly meetings and/or conference calls will take place for the first year of indicator and measurement strategy development/ implementation. Meetings will be workgroup oriented, and work products (e.g., documents) may be expected from

committee members as a result of meetings and out-of-meeting assignments. It is important for continuity that nearly all members participate in all meetings and committee assignments.

For consumers and family members, the cost of travel, accommodations, and a per diem for expenses will be supported by DMH. Committee members (other than consumers and family members) will be volunteering their time and associated resources. County representatives may use allocated MHSA funds to support participation on the committee.

Nominations are currently being taken for approximately 20 positions on the Performance Measurement Committee. To nominate someone (or yourself), please complete the Nomination Form (next page) and include a resume. Please limit the resume to a maximum of 3 pages.

Please fax the completed nomination form and resume to: Candace Cross-Drew at (916) 653-5500. All nominations must be received by June 30, 2005.

Each nomination will be carefully reviewed by DMH and approximately 20 nominees will be selected who collectively reflect the needed diversity, regional representation, multiple perspectives and areas of expertise.

NOMINATION FORM
DMH Performance Measurement Committee

1. *Your Name:* _____

Your Tel#: _____ Your Email: _____

2. *Name of Person you are Nominating (It can be yourself):*

Tel#: _____ Email: _____

3. *Please tell us about the nominee:*

County or agency / organization affiliation:

Current job title or capacity within organization:

Is the nominee a Consumer? ☐ Yes ☐ No

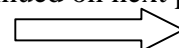
Is the nominee a family member / caregiver of a Consumer? ☐ Yes ☐ No

Please check the following areas of expertise / perspectives as they relate to the nominee.

PLEASE CHECK ALL THAT APPLY.

- ☐ Consumer perspective
- ☐ Family member/caregiver perspective
- ☐ Small County perspective/expertise
- ☐ Large County perspective/expertise
- ☐ Rural County perspective/expertise
- ☐ Urban County perspective/expertise
- ☐ Child /Youth perspective/expertise

Continued on next page



- ☐ Transition - Age Youth perspective/expertise
- ☐ Adult perspective/expertise
- ☐ Older Adult perspective/expertise
- ☐ Research /Evaluation /Measurement expertise
- ☐ Cultural competence expertise
- ☐ Mental health administrative experience, e.g., management
- ☐ Expertise in Recovery/Wellness philosophy / orientation
- ☐ Mental health services delivery / clinical experience

4. Please let us know about any other perspectives and/or areas of expertise that you believe the nominee possesses that would make a significant contribution to the committee.

5. Please provide any additional information about the nominee that you feel might be helpful.

Please remember to include the nominee's resume.

Fax to Candace Cross-Drew at (916) 653-5500 by June 30, 2005.

DMH DRAFT

PUBLIC / COMMUNITY- IMPACT LEVEL

(Evaluation of Global Impacts and Community-Focused Strategies)

Mental Health
Promotion
and
Awareness

Mental Health
System
Structure /
Capacity in
Community

Community
Reaction /
Evaluation /
Satisfaction with
regard to mental
health system

Large-Scale
Community
Indicators

MENTAL HEALTH SYSTEM ACCOUNTABILITY LEVEL

(Evaluation of Community Integrated Services and Supports – *Program/System-Based Measurement*)

Monitoring /
Quality
Assurance /
Oversight
(multi-
stakeholder
process)

Client / Family
Satisfaction /
Evaluation of
Services and
Supports

Staff / Provider
Evaluation /
Satisfaction
with regard to
mental health
system

INDIVIDUAL CLIENT LEVEL

(Evaluation of Community Integrated Services and Supports – *Individual Client Tracking*)

**Client and
Services
Tracking**

**Individual
Client
Outcomes
Tracking**

DMH DRAFT PERFORMANCE MEASUREMENT

INDIVIDUAL CLIENT LEVEL

(Evaluation of Community Integrated Services and Supports – *Individual Client Tracking*)

Client and Services Tracking (Examples)

- Client-specific information, e.g., contact, demographic information, reason for system disengagement, etc.
- Services / supports information, e.g., new services/programs/supports pertinent to the MHSA, evidence-based practices, levels of care, partnering agency/provider services, etc.

(Client and services/supports data capture is envisioned to be achieved through interoperable information systems residing at both the state and local levels. A phased-in approach will be used to achieve this long-term goal of full interoperability.)

Individual Client Outcomes Tracking (Examples)

- Initial and periodic bio/psycho/social assessments
- Ongoing assessments of core outcomes. The following are examples

Recovery & Wellness Oriented Client Outcome Indicators : (These are examples; indicators and measures to be determined though stakeholder and committee recommendations.) Hopefulness Wellness Empowerment Self-efficacy, Etc...	Housing	Functioning
	Criminal justice system involvement	Substance Abuse
	Employment / Education	Quality of Life
	Hospitalization (acute//long term restrictive levels of care)	Illness self-management
	Income / Entitlements	Social / community connectedness
	Family preservation	Individual service plan goals
	Symptoms / Suffering	Physical health
	Suicide	Etc.

(State and local information systems interoperability, based on statewide standards, will be the mechanism by which this client outcome information is captured. DMH will work with counties/providers to provide flexible system options with regard to measurement of outcome indicators.)

DMH DRAFT PERFORMANCE MEASUREMENT

MENTAL HEALTH SYSTEM ACCOUNTABILITY LEVEL

(Evaluation of Community Integrated Services and Supports – *Program/System-Based Measurement*)

Monitoring / Quality Assurance / Oversight *(multi-stakeholder process) (Examples)*

Local / county plans and performance with respect to:

- Cultural competency / no disparities
- Recovery / Resilience philosophy and promotion
- Full participation of clients / family members in service delivery system processes
- Fidelity to evidence-based practice guidelines or model programs
- Adherence to budget / timelines
- Staff / provider competencies
- Adherence to appropriate client-to-staff ratios
- Quality (performance) improvement projects
- Service partnerships - Comprehensive / inter-agency / coordinated service delivery
- Supportive services (e.g., housing, employment, peer-delivered supportive services)
- Coordinated services for co-occurring disorders
- Costs, cost-effectiveness of services
- Etc.

*(Measured with standardized review criteria, monitoring tools, electronic data entry / reporting interfaces, etc.
Cost information to be associated with client, service, and outcomes tracking information to determine costs per client, cost-effectiveness and cost-benefit analyses of programs, etc.)*

Client / Family Satisfaction / Evaluation of Services and Supports *(Examples)*

- Mental Health Statistics Improvement Program (MHSIP) indicators and surveys
- Surveys / assessments targeting specific services / supports appraisal by clients / families / caregivers
- Focus groups / multiple means of eliciting client / family / caregiver input
- Etc.

Staff / Provider Evaluation / Satisfaction with regard to mental health system *(Examples)*

- Perceived effectiveness of the structure of system, inter-agency issues, effectiveness of service models, etc.
 - Interviews / surveys/ focus groups
- Etc.

PERFORMANCE MEASUREMENT

DMH DRAFT

PUBLIC / COMMUNITY- IMPACT LEVEL

(Evaluation of Global Impacts and Community-Focused Strategies)

Mental Health Promotion and Awareness (Examples)

- Outreach services (e.g., homeless, rural communities, Tele-health, etc.)
- Community Emergency Response Team Services
- Community Mental Health / Depression Screenings
- Educational Seminars (e.g., general public, primary care settings, schools, etc.)
- Anti-Stigma and Anti-Discrimination Campaigns
- Prevention and Early Intervention Efforts
- Workforce Recruitment and Development (e.g., university, licensing board collaborations, continuing education)
- Community Support Groups
- Media, public awareness announcements, (e.g., Recovery & Resiliency)
- Access and educational enhancements (e.g., Network of Care website, promotion of recovery philosophy)
- Etc

(Typically measured by counts of individuals reached, screened, informed, etc.)

Mental Health System Structure / Capacity in Community (Examples)

- Inventory of available services & supports
- Location of services, including inter-agency, outreach, mobile, natural setting, etc (e.g., GIS mapping)
- Etc.

Community Reaction / Evaluation / Satisfaction with regard to mental health system (Examples)

- Media reviews
- Interviews with public officials
- Assessment of community members
- Etc.

Large-Scale Community Indicators (Examples)

- Population prevalence of mental illness
- Community mental health need / unmet need
- Percents of youth in juvenile justice or Level12-14 group home placements
- Etc.

CSI DATA DICTIONARY

LIST OF DATA FIELDS

<u>FIELD NUMBER</u>	<u>FIELD NAME</u>
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Header Fields:

H-01.0	COUNTY/CITY/MENTAL HEALTH PLAN SUBMITTING RECORD (SUBMITTING COUNTY CODE)
H-02.0	COUNTY CLIENT NUMBER (CCN)
H-03.0	RECORD TYPE
H-04.0	TRANSACTION CODE

Control Fields:

X-01.0	PRODUCTION OR TEST INDICATOR
X-02.0	FROM REPORT PERIOD
X-03.0	THROUGH REPORT PERIOD
X-04.0	CREATION DATE
X-05.0	KEY CHANGE RECORD COUNT
X-06.0	CLIENT RECORD COUNT
X-07.0	SERVICE RECORD COUNT
X-08.0	PERIODIC RECORD COUNT

Client Fields:

C-01.0	BIRTH NAME
C-02.0	MOTHER'S FIRST NAME
C-03.0	DATE OF BIRTH
C-04.0	PLACE OF BIRTH
C-05.0	GENDER
C-06.0	ETHNICITY/RACE
C-07.0	PRIMARY LANGUAGE

CSI DATA DICTIONARY

FIELD

NUMBER **FIELD NAME**

Service Fields:

S-01.0	RECORD REFERENCE NUMBER (RRN)
S-02.0	CURRENT LEGAL NAME / BENEFICIARY NAME
S-03.0	SOCIAL SECURITY NUMBER
S-04.0	MEDI-CAL NUMBER (OPTIONAL)
S-05.0	MODE OF SERVICE
S-06.0	SERVICE FUNCTION
S-07.0	UNITS OF SERVICE
S-08.0	UNITS OF TIME
S-09.0	PRINCIPAL MENTAL HEALTH DIAGNOSIS
S-10.0	SECONDARY MENTAL HEALTH DIAGNOSIS
S-11.0	ADDITIONAL MENTAL OR PHYSICAL HEALTH DIAGNOSIS
S-12.0	SPECIAL POPULATION
S-13.0	PROVIDER NUMBER
S-14.0	COUNTY/CITY/MENTAL HEALTH PLAN WITH FISCAL RESPONSIBILITY FOR CLIENT

Service Fields - 24 Hour Mode of Service:

S-15.0	ADMISSION DATE
S-16.0	FROM/ENTRY DATE
S-17.0	THROUGH/EXIT DATE
S-18.0	DISCHARGE DATE
S-19.0	PATIENT STATUS CODE

Service Fields - Hospital, PHF, and SNF:

S-20.0	LEGAL CLASS - ADMISSION
S-21.0	LEGAL CLASS - DISCHARGE
S-22.0	ADMISSION NECESSITY CODE

Service Fields - Non-24 Hour Mode of Service:

S-23.0	DATE OF SERVICE
S-24.0	PLACE OF SERVICE

CSI DATA DICTIONARY

**FIELD
NUMBER FIELD NAME**

Periodic Fields:

P-01.0	DATE COMPLETED
P-02.0	EDUCATION
P-03.0	EMPLOYMENT STATUS
P-04.0	AXIS-V / GAF
P-05.0	OTHER FACTORS AFFECTING MENTAL HEALTH -SUBSTANCE ABUSE
P-06.0	OTHER FACTORS AFFECTING MENTAL HEALTH - DEVELOPMENTAL DISABILITIES
P-07.0	OTHER FACTORS AFFECTING MENTAL HEALTH - PHYSICAL HEALTH DISORDERS
P-08.0	CONSERVATORSHIP / COURT STATUS
P-09.0	LIVING ARRANGEMENT

Key Change Fields:

K-01.0	FIRST SOURCE COUNTY CLIENT NUMBER
K-02.0	ADDITIONAL SOURCE COUNTY CLIENT NUMBER

Error Fields:

E-01.0	ERROR LEVEL
E-02.0	FIELD / RELATIONAL AND SYSTEM CODE
E-03.0	ERROR CODE

AB2034/ACT ALL PURPOSE CHANGE OF STATUS FORM (3 Page Version - Page 1 of 3)

Consumer Name: _____ MIS Number: _____

Staff Name: _____ Date Form Completed: _____

RESIDENTIAL Date of Status Change: _____

(Place a check to the LEFT of the code of the Consumer's NEW residential status below)

____ 1. Jail or Prison (> 30 Days)	____ 9. Transitional Residential Program	____ 17. With Adult Family Members
____ 2. Homeless	____ 10. Long Term Residential Program	____ 18. Sober Living Home
____ 3. Emergency Shelter	____ 11. Institutional Foster Care	____ 19. Supportive Housing
____ 4. Temporary Housing	____ 12. Alcohol or Substance Abuse Residential Rehab Center	____ 20. Single Room Occupancy (SRO)
____ 5. State Psychiatric Hospital / Acute Hospital (> 30 Days)	____ 13. Licensed Community Care Facility (Board and Care)	____ 21. With Unrelated Others
____ 6. Skilled Nursing Facility (SNF)– PHYSICAL REASONS	____ 14. Family-Based Foster Care	____ 22. Alone or w/Spouse/Partner/Minor Children/Other Dependents
____ 7. SNF, IMD, MHRC – PSYCH. REASONS	____ 15. Residential Placement w/Paid, Unrelated, Unlicensed Caretaker(s)	____ 49. Other _____
____ 8. Crisis Residential Program	____ 16. Group Living Home	XXXXXX

*Housing subsidy? How much per month? \$ _____ Type of Subsidy (Check all that apply): Section 8 _____ Shelter Plus _____ Other _____

 Facility Name Street Address City Zip Phone (____) _____

EMPLOYMENT Date of Status Change: _____

(Place a check to the LEFT of the code of the Consumer's NEW employment status below)

<input type="checkbox"/> 199. Unemployed	<input type="checkbox"/> 3. Non-paid Work Experience	<input type="checkbox"/> 6. Agency owned Business	<input type="checkbox"/> 9. Supported Employment
<input type="checkbox"/> 1. Employment Preparation	<input type="checkbox"/> 4. Sheltered Workshop	<input type="checkbox"/> 7. Enclave	<input type="checkbox"/> 10. Competitive Employment
<input type="checkbox"/> 2. Placement/Referral Ready	<input type="checkbox"/> 5. Paid Work Experience	<input type="checkbox"/> 8. Transitional Employment	

 Business Name Street Address City Zip Phone (____) _____

Contact Person: _____ Start Date: _____ Hourly Wage: _____ Hours per week: _____

*** If the Consumer's financial status has changed (e.g., increase/decrease in wages) as a result of the change in employment status, you MUST fill out the FINANCIAL section immediately below

FINANCIAL Date of Status Change: _____

(Enter the new MONTHLY amount for any category that is changing)

Source of Income	Amount per Month	Source of Income	Amount per Month	Source of Income	Amount per Month
GR/GA	\$ _____	Family	\$ _____	Food Stamps	\$ _____
SSI/SSDI	\$ _____	Employment	\$ _____	VA Benefits	\$ _____
SDI	\$ _____	TANF	\$ _____	Other	\$ _____

*** If a Consumer's financial status is changing as a result of getting a job or an increase in wages, the HOURLY wage must be converted to a MONTHLY amount. To do this multiply the hourly wage by the number of hours per week by 4. For example, a consumer gets a job paying \$7.50 per hour, 15 hours per week. The Consumer's monthly wage in this case would be \$7.50 X 15 X 4 = \$450.00.

INSURANCE PAYER STATUS Date of Change: _____

(Place a check next to the Consumers' new insurance payer code)

Medicaid (1) _____	Short-Doyle/County (2) _____	Private Pay (3) _____	Insurance/HMO (4) _____	Medicare (5) _____
Veteran's Health (VA) (6) _____	Medicaid/Medicare (7) _____	CMSP (8) _____	Kaiser Contract (9) _____	Other (49) _____

AB34 ALL PURPOSE CHANGE OF STATUS FORM (3 Page Version - Page 2 of 3)

Consumer Name: _____ MIS Number: _____

Staff Name: _____ Date Form Completed: _____

EDUCATION Date of Status Change: _____

(Place a check to the LEFT of the code of the Consumer's NEW education status below)

XXXXXXXXXXXXXXXXXXXXXXXXXXXX		3. GED preparation		7. Community college
199. Not in school		4. High School		8. Four year college
1. One time only lecture, class, workshop or seminar		5. Adult Education		9. Graduate training
2. Pre-education classes/activities		6. Technical/vocational training		49. Other

1. _____ Average number hours per week the member will be going to school in new status (Enter from 0 to 40)

Answer questions 2 and 3 ONLY if the member is **STOPPING** (Code 199) school or training (e.g., successful completion of a quarter or semester term, graduation, summer vacation, dropping out). **DO NOT** change the Consumer's education status for Christmas Break or Spring Break.

****An Education change of status code of 199 (Not in school) should be entered whenever a member completes a class, quarter, semester, or yearly term of instruction, even if the consumer will be continuing in the same course of instruction. For example, a Consumer is enrolled in a community college on 9/2/2003 and remains in school until the end of the semester on 12/19/2003. A code of 7 (Community college) should be entered for 9/2/2003 and a code of 199 (Not in school) should be entered for 12/19/2003. If the Consumer then begins the Winter semester on 1/26/2004, another Education change of status of 7 would need to be entered for 1/26/2004.*

2. _____ Yes _____ No Did member successfully complete a current term or course (e.g., quarter or semester)?

3. _____ Yes _____ No Did member successfully complete a school or training program (e.g., received A.A., B.A., GED, Vocational certification)?

Answer questions 4, 5, and 6 ONLY if the member is **BEGINNING** school or training.

4. _____ Yes _____ No Will the member be formally enrolled in a new class/course?5. _____ Yes _____ No Will the member be enrolled in a program with a goal beyond the completion of this particular course, class, or term?6. _____ New _____ Continuing Is this a new program for the member or the continuation of a program in which the member is already enrolled?**HOSPITALIZATION (***A hospitalization of more than 30 days requires a Residential change of status to code 5)**

Date of: Admission: _____ Discharge: _____ Transfer: _____

Facility Name _____ Street Address _____ City _____ Zip _____ (_____) Phone _____

1. Type of Hospitalization (Check One): Psychiatric or Substance Abuse _____ Medical/Surgical _____

2. Is this admission/transfer **voluntary** or **involuntary** (Check One)? Voluntary _____ Involuntary _____3. _____ YES _____ NO Is the admission/transfer forensic in nature (i.e., the result of contact with the criminal justice system)?4. _____ YES _____ NO Is the admission/transfer substance abuse related, (e.g., a member is being hospitalized for detox)?5. _____ YES _____ NO Is the member being discharged AGAINST MEDICAL ADVICE?**EMERGENCY ROOM / CRISIS STABILIZATION USE** Date of ER/CSU Visit: _____(Check **One** only)

EMERGENCY ROOM _____

CRISIS STABILIZATION UNIT _____

Indicate if this emergency room / Crisis Stabilization Unit visit was mental illness related (e.g., psychotic episode), substance abuse related (e.g., drug overdose), physical illness related (e.g., broken leg, appendicitis) or unknown/other (Circle all that apply).

Mental Illness Related?	Substance Abuse Related?	Physical Health Related?	Unknown/Other Reason?
YES NO UNCLEAR	YES NO UNCLEAR	YES NO UNCLEAR	YES NO UNCLEAR

AB34 ALL PURPOSE CHANGE OF STATUS FORM (3 Page Version - Page 3 of 3)

Consumer Name: _____ MIS Number: _____

Staff Name: _____ Date Form Completed: _____

INCARCERATION (**An incarceration of more than 30 days requires a Residential change of status to code 1)

Date of: Incarceration: _____ Release: _____ Transfer: _____

Facility Name _____ Street Address _____ City _____ Zip _____ Phone (____) _____

1. Facility Type (Check one): State Prison: _____ City/County Jail: _____ Other: _____
2. _____ YES _____ NO Is the incarceration/transfer primarily psychiatric in nature (i.e., the crime was a direct result of the member's psychiatric condition; e.g., a member is being incarcerated because she broke into a home in a delusional state)?
3. _____ YES _____ NO Is the incarceration/transfer primarily substance abuse related, (e.g., a member was arrested because he was engaged in prostitution to supply a drug habit or a member was arrested while she was buying drugs)?
4. _____ YES _____ NO Is the incarceration for a crime that was committed PRIOR to the Consumer's enrollment in the AB 34 program?

CRIMINAL JUSTICE (LEGAL) SYSTEM CONTACT Date of Event: _____ (Check all that apply)

Police Contact, no citation _____ Police Contact, citation _____ Misdemeanor Arrest _____ Felony Arrest _____
Misdemeanor Conviction _____ Felony Conviction _____ Placed on Probation _____ Placed on Parole _____
Removed from Probation _____ Removed from Parole _____ Violent Victimization _____ Other Victimization _____

1. _____ YES _____ NO _____ UNCLEAR Was this contact with the criminal justice system "mental illness-related"? i.e., Were the symptoms of the illness the reason for the arrest or did the illness significantly impair the person from understanding or obeying the law (e.g., a member arrested for loitering because s/he was not taking medication and therefore in a psychotic state would be a mental illness-related arrest. A member who was arrested for committing assault while not in a psychotic state would not be a mental illness-related arrest).
2. _____ YES _____ NO _____ UNCLEAR Was this contact with the criminal justice system "substance abuse-related"? i.e., Was the member under the influence of drugs or alcohol, either intoxication or withdrawal, or was the crime clearly part of drug seeking behavior? (e.g., a member arrested for loitering because s/he was inebriated on alcohol would be a substance abuse-related arrest. A member who was completely sober who was apprehended for selling drugs would not be considered a substance abuse-related arrest).

CONSERVATORSHIP STATUS Date of Conservatorship Change: _____

_____ (199) Check if member is being removed from conservatorship status?

_____ (10) Check if member is being placed on conservatorship status or changing to a new conservator?

Conservator Name _____ Street Address _____ City _____ Zip _____ Phone (____) _____

PAYEE STATUS Date of Payee Change: _____

_____ (199) Check if member is being removed from payee status?

_____ (10) Check if the member is being placed on payee status or changing to a new payee?

Payee Name _____ Street Address _____ City _____ Zip _____ Phone (____) _____

Reason placed on Payee Status (Check all that apply)	Reason taken off Payee Status (Check all that apply)
1. _____ Homeless	1. _____ Graduated from money management
2. _____ Abusing substances	2. _____ Competent to handle own funds
3. _____ Initial SSI	3. _____ Outside MD removed payee status
4. _____ DA & A status imposed	4. _____ Staff unable to work with payee
5. _____ Hungry	5. _____ SSA removed payee status
6. _____ Conservatorship imposed	6. _____ Conservatorship removed

YOUTH SERVICES SURVEY FOR FAMILIES* (YSS-F)

Please help our agency make services better by answering some questions. Your answers are confidential and will not influence current or future services you or your child will receive. **For each survey item below, please fill in the circle that corresponds to your choice. Please fill in the circle completely.** *EXAMPLE:* Correct ☐ Incorrect ☒

Please answer the following questions based on the **last 6 months** OR if services have not been received for 6 months, just give answers based on the services that have been received so far. Indicate if you **Strongly Disagree**, **Disagree**, are **Undecided**, **Agree**, or **Strongly Agree** with each of the statements below. If the question is about something you or your child have not experienced, fill in the circle for **Not Applicable** to indicate that this item does not apply.

**START
HERE**

Approximately, how long has your child received services here?

- ☐ This is my child's first visit here. ☐ 1 - 2 Months ☐ More than 1 year
☐ My child has had more than one visit but has received services for less than one month. ☐ 3 - 5 Months ☐ 6 months to 1 year

	Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree	Not Applicable
1. Overall, I am satisfied with the services my child received.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2. I helped to choose my child's services.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3. I helped to choose my child's treatment goals.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4. The people helping my child stuck with us no matter what.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
5. I felt my child had someone to talk to when he / she was troubled.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
6. I participated in my child's treatment.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
7. The services my child and / or family received were right for us.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
8. The location of services was convenient for us.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
9. Services were available at times that were convenient for us.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
10. My family got the help we wanted for my child.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
11. My family got as much help as we needed for my child.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
12. Staff treated me with respect.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
13. Staff respected my family's religious / spiritual beliefs.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
14. Staff spoke with me in a way that I understood.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
15. Staff were sensitive to my cultural / ethnic background.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

As a result of the services my child and / or family received:

16. My child is better at handling daily life.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
17. My child gets along better with family members.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
18. My child gets along better with friends and other people.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
19. My child is doing better in school and / or work.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
20. My child is better able to cope when things go wrong.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
21. I am satisfied with our family life right now.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
22. Please provide comments here and /or on the back of this form, if needed.						

We are interested in both positive and negative feedback.

*Molly Brunk, Ph.D., 1999. This instrument was developed as part of the State Indicator Project funded by the Center for Mental Health Services (CMHS). It was adapted from the Family Satisfaction Questionnaire used with the CMHS Comprehensive Community Mental Services for Children and their Families Program and the MHSIP Consumer Survey.

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CSI County Client Number
Must be entered on EVERY page

P	-	E	N	0	5	/	0	1	/	0	5
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Please answer the following questions to let us know a little about your child.

ENGLISH
Family Survey

1. What is your child's gender? ☐ Female ☐ Male ☐ Other
 2. Are either of the child's parents of Mexican / Hispanic / Latino origin? ☐ Yes ☐ No ☐ Unknown
 3. What is your child's race? (Mark all that apply.)
☐ White / Caucasian ☐ American Indian / Alaskan Native ☐ Unknown
☐ Black / African American ☐ Native Hawaiian / Other Pacific Islander
☐ Asian ☐ Other
 4. What is your child's date of birth? (Write it in the boxes AND fill in the circles that correspond. See Example.)
 Date of Birth (mm-dd-yyyy)

		-					
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0	0	0	0	0	0	0	0
1	1	1	1	1	1	1	1
2	2	2	2	2	2	2	2
3	3	3	3	3	3	3	3
4	4	4	4	4	4	4	4
5	5	5	5	5	5	5	5
6	6	6	6	6	6	6	6
7	7	7	7	7	7	7	7
8	8	8	8	8	8	8	8
9	9	9	9	9	9	9	9
- EXAMPLE:** Date of birth on April 30, 1987:
1. Write in your child's date of birth → 04 - 30 - 1987
2. Fill in the corresponding circles
- | | | | | | | | |
|---|---|---|---|---|---|---|---|
| 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| 2 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| 3 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| 4 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| 5 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| 6 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| 7 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| 8 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| 9 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |

5. In the **past MONTH**, how many times was your child arrested for any crimes?
☐ No arrests ☐ 1 arrest ☐ 2 arrests ☐ 3 arrests ☐ 4 or more arrests
6. How often was your child absent from school during the **last MONTH**?
☐ 1 day or less ☐ 3 to 5 days ☐ More than 10 days ☐ Do not remember
☐ 2 days ☐ 6 to 10 days ☐ Not applicable / Not in school
7. Were the services your child received provided in the language he / she preferred? ☐ Yes ☐ No
8. Was written information (e.g., brochures describing available services, your rights as a consumer, and mental health education materials) available to you in the language you prefer? ☐ Yes ☐ No
9. Please identify who helped you complete any part of this survey (Mark all that apply):
☐ I did not need any help. ☐ A professional interviewer helped me.
☐ A mental health advocate / volunteer helped me. ☐ My child's clinician / case manager helped me.
☐ Another mental health consumer helped me. ☐ A staff member other than my child's clinician or case manager helped me.
☐ A member of my family helped me. ☐ Someone else helped me. Who?: _____

Thank you for taking the time to answer these questions!

FOR OFFICE USE ONLY:

REQUIRED Information:

County Code:

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Date of Survey Administration:

0	5	-			-	2	0	0	5
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Reason (if applicable):

Ref ☐ Imp ☐ Lan ☐ Oth ☐

Make sure the same CSI County Client Number is written on all pages of this survey.

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CSI County Client Number
Must be entered on EVERY page

Optional County Questions:

County Question #1 (mark only ONE bubble):

☐ 01 ☐ 02 ☐ 03 ☐ 04 ☐ 05 ☐ 06 ☐ 07 ☐ 08 ☐ 09 ☐ 10
☐ 11 ☐ 12 ☐ 13 ☐ 14 ☐ 15 ☐ 16 ☐ 17 ☐ 18 ☐ 19 ☐ 20

County Question #2 (mark only ONE bubble):

☐ 01 ☐ 02 ☐ 03 ☐ 04 ☐ 05 ☐ 06 ☐ 07 ☐ 08 ☐ 09 ☐ 10
☐ 11 ☐ 12 ☐ 13 ☐ 14 ☐ 15 ☐ 16 ☐ 17 ☐ 18 ☐ 19 ☐ 20

County Question #3 (mark only ONE bubble):

☐ 01 ☐ 02 ☐ 03 ☐ 04 ☐ 05 ☐ 06 ☐ 07 ☐ 08 ☐ 09 ☐ 10
☐ 11 ☐ 12 ☐ 13 ☐ 14 ☐ 15 ☐ 16 ☐ 17 ☐ 18 ☐ 19 ☐ 20

49872



YOUTH SERVICES SURVEY* (YSS)

Please help our agency make services better by answering some questions. Your answers are confidential and will not influence current or future services you receive. **For each survey item below, please fill in the circle that corresponds to your choice. Please fill in the circle completely.** *EXAMPLE:* Correct ● Incorrect ✗ ✓

Please answer the following questions based on the **last 6 months** OR if you have not received services for 6 months, just give answers based on the services you have received so far. Indicate if you **Strongly Disagree**, **Disagree**, are **Undecided**, **Agree**, or **Strongly Agree** with each of the statements below. If the question is about something you have not experienced, fill in the circle for **Not Applicable** to indicate that this item does not apply to you.

**START
HERE**



Approximately, how long have you received services here?

- This is my first visit here. ○ 1 - 2 Months ○ More than 1 year
○ I have had more than one visit but I have received services for less than one month. ○ 3 - 5 Months
○ 6 months to 1 year

	Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree	Not Applicable
1. Overall, I am satisfied with the services I received.	○	○	○	○	○	○
2. I helped to choose my services.	○	○	○	○	○	○
3. I helped to choose my treatment goals.	○	○	○	○	○	○
4. The people helping me stuck with me no matter what.	○	○	○	○	○	○
5. I felt I had someone to talk to when I was troubled.	○	○	○	○	○	○
6. I participated in my own treatment.	○	○	○	○	○	○
7. I received services that were right for me.	○	○	○	○	○	○
8. The location of services was convenient.	○	○	○	○	○	○
9. Services were available at times that were convenient for me.	○	○	○	○	○	○
10. I got the help I wanted.	○	○	○	○	○	○
11. I got as much help as I needed.	○	○	○	○	○	○
12. Staff treated me with respect.	○	○	○	○	○	○
13. Staff respected my family's religious / spiritual beliefs.	○	○	○	○	○	○
14. Staff spoke with me in a way that I understood.	○	○	○	○	○	○
15. Staff were sensitive to my cultural / ethnic background.	○	○	○	○	○	○

As a result of the services I received:

16. I am better at handling daily life.	○	○	○	○	○	○
17. I get along better with family members.	○	○	○	○	○	○
18. I get along better with friends and other people.	○	○	○	○	○	○
19. I am doing better in school and / or work.	○	○	○	○	○	○
20. I am better able to cope when things go wrong.	○	○	○	○	○	○
21. I am satisfied with my family life right now.	○	○	○	○	○	○
22. Please provide comments here and /or on the back of this form, if needed.						

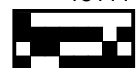
We are interested in both positive and negative feedback.

*Molly Brunk, Ph.D., 1999. This instrument was developed as part of the State Indicator Project funded by the Center for Mental Health Services (CMHS). It was adapted from the Family Satisfaction Questionnaire used with the CMHS Comprehensive Community Mental Services for Children and their Families Program and the MHSIP Consumer Survey.

CONTINUED ON NEXT PAGE...

CSI County Client Number
Must be entered on EVERY page

Y - EN 0 5 / 0 1 / 0 5



Please answer the following questions to let us know a little about you.

ENGLISH
Youth Survey

1. What is your gender? ☐ Female ☐ Male ☐ Other
2. Are you of Mexican / Hispanic / Latino origin? ☐ Yes ☐ No ☐ Unknown
3. What is your race? (Mark all that apply.)
☐ White / Caucasian ☐ American Indian / Alaskan Native ☐ Unknown
☐ Black / African American ☐ Native Hawaiian / Other Pacific Islander
☐ Asian ☐ Other
4. What is your date of birth? (Write it in the boxes AND fill in the circles that correspond. See Example.)

Date of Birth (mm-dd-yyyy)

		-			-				
0	0	0	0	0	0	0	0	0	0
1	1	1	1	1	1	1	1	1	1
2	2	2	2	2	2	2	2	2	2
3	3	3	3	3	3	3	3	3	3
4	4	4	4	4	4	4	4	4	4
5	5	5	5	5	5	5	5	5	5
6	6	6	6	6	6	6	6	6	6
7	7	7	7	7	7	7	7	7	7
8	8	8	8	8	8	8	8	8	8
9	9	9	9	9	9	9	9	9	9

EXAMPLE: Date of birth on April 30, 1987:

1. Write in your date of birth → 04 - 30 - 1987

2. Fill in the corresponding circles

0	0	0	0	0	0	0	0	0	0
1	0	0	0	0	0	0	0	0	0
2	0	0	0	0	0	0	0	0	0
3	0	0	0	0	0	0	0	0	0
4	0	0	0	0	0	0	0	0	0
5	0	0	0	0	0	0	0	0	0
6	0	0	0	0	0	0	0	0	0
7	0	0	0	0	0	0	0	0	0
8	0	0	0	0	0	0	0	0	0
9	0	0	0	0	0	0	0	0	0

5. In the **past MONTH**, how many times have you been arrested for any crimes?
☐ No arrests ☐ 1 arrest ☐ 2 arrests ☐ 3 arrests ☐ 4 or more arrests
6. How often were you absent from school during the **last MONTH**?
☐ 1 day or less ☐ 3 to 5 days ☐ More than 10 days ☐ Do not remember
☐ 2 days ☐ 6 to 10 days ☐ Not applicable / Not in school
7. Were the services you received provided in the language you prefer? ☐ Yes ☐ No
8. Was written information (e.g., brochures describing available services, your rights as a consumer, and mental health education materials) available to you in the language you prefer? ☐ Yes ☐ No
9. Please identify who helped you complete any part of this survey (Mark all that apply):
☐ I did not need any help. ☐ A professional interviewer helped me.
☐ A mental health advocate / volunteer helped me. ☐ My clinician / case manager helped me.
☐ Another mental health consumer helped me. ☐ A staff member other than my clinician or case manager helped me.
☐ A member of my family helped me. ☐ Someone else helped me. Who?: _____

Thank you for taking the time to answer these questions!

FOR OFFICE USE ONLY:

REQUIRED Information:

County Code:

Date of Survey Administration:

0 5 - - 2 0 0 5

Reason (if applicable):

Ref ☐ Imp ☐ Lan ☐ Oth ☐

Make sure the same CSI County Client Number is written on all pages of this survey.

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CSI County Client Number
Must be entered on EVERY page

Optional County Questions:

County Question #1 (mark only ONE bubble):

☐ 01 ☐ 02 ☐ 03 ☐ 04 ☐ 05 ☐ 06 ☐ 07 ☐ 08 ☐ 09 ☐ 10
☐ 11 ☐ 12 ☐ 13 ☐ 14 ☐ 15 ☐ 16 ☐ 17 ☐ 18 ☐ 19 ☐ 20

County Question #2 (mark only ONE bubble):

☐ 01 ☐ 02 ☐ 03 ☐ 04 ☐ 05 ☐ 06 ☐ 07 ☐ 08 ☐ 09 ☐ 10
☐ 11 ☐ 12 ☐ 13 ☐ 14 ☐ 15 ☐ 16 ☐ 17 ☐ 18 ☐ 19 ☐ 20

County Question #3 (mark only ONE bubble):

☐ 01 ☐ 02 ☐ 03 ☐ 04 ☐ 05 ☐ 06 ☐ 07 ☐ 08 ☐ 09 ☐ 10
☐ 11 ☐ 12 ☐ 13 ☐ 14 ☐ 15 ☐ 16 ☐ 17 ☐ 18 ☐ 19 ☐ 20

18111



ADULT SURVEY

Please help our agency make services better by answering some questions. Your answers are confidential and will not influence current or future services you receive. **For each survey item below, please fill in the circle that corresponds to your choice.** Please fill in the circle completely. EXAMPLE: Correct ☐ Incorrect ☒

MHSIP Consumer Survey*:

Please answer the following questions based on the last 6 months OR if you have not received services for 6 months, just give answers based on the services you have received so far. Indicate if you **Strongly Agree**, **Agree**, are **Neutral**, **Disagree**, or **Strongly Disagree** with each of the statements below. If the question is about something you have not experienced, fill in the circle for **Not Applicable** to indicate that this item does not apply to you.

**START
HERE**

Approximately, how long have you received services here?

- ☐ This is my first visit here. ☐ 1 - 2 Months ☐ More than 1 year
☐ I have had more than one visit but I have received services for less than one month. ☐ 3 - 5 Months ☐ 6 months to 1 year

	Strongly Agree	Agree	I am Neutral	Disagree	Strongly Disagree	Not Applicable
1. I like the services that I received here.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2. If I had other choices, I would still get services from this agency.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3. I would recommend this agency to a friend or family member.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4. The location of services was convenient (parking, public transportation, distance, etc.).	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
5. Staff were willing to see me as often as I felt it was necessary.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
6. Staff returned my calls within 24 hours.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
7. Services were available at times that were good for me.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
8. I was able to get all the services I thought I needed.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
9. I was able to see a psychiatrist when I wanted to.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
10. Staff here believe that I can grow, change and recover.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
11. I felt comfortable asking questions about my treatment and medication.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
12. I felt free to complain.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
13. I was given information about my rights.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
14. Staff encouraged me to take responsibility for how I live my life.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
15. Staff told me what side effects to watch out for.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
16. Staff respected my wishes about who is, and who is not to be given information about my treatment.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
17. I, not staff, decided my treatment goals.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
18. Staff were sensitive to my cultural background (race, religion, language, etc.).	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
19. Staff helped me obtain the information I needed so that I could take charge of managing my illness.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
20. I was encouraged to use consumer-run programs (support groups, drop-in centers, crisis phone line, etc.).	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

*The MHSIP Consumer Survey was developed through a collaborative effort of consumers, the Mental Health Statistics Improvement Program (MHSIP) community, and the Center for Mental Health Services.

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CSI County Client Number
Must be entered on EVERY page

A	-	E	N	0	5	/	0	1	/	0	5
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As a direct result of the services I received:

	Strongly Agree	Agree	I am Neutral	Disagree	Strongly Disagree	Not Applicable
21. I deal more effectively with daily problems.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
22. I am better able to control my life.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
23. I am better able to deal with crisis.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
24. I am getting along better with my family.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
25. I do better in social situations.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
26. I do better in school and /or work.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
27. My housing situation has improved.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
28. My symptoms are not bothering me as much.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
29. Please provide comments here and /or on the back of this form, if needed. We are interested in both positive and negative feedback.						

Quality of Life Questions:

Please answer each of the following questions by filling in the circle that best describes your experience or how you feel. Please fill in only one circle for each question. For some questions, you may choose **Not Applicable** if the question does not apply to you.

General Life Satisfaction

	Terrible	Unhappy	Mostly Dissatisfied	Mixed	Mostly Satisfied	Pleased	Delighted
1. How do you feel about your life in general?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Living Situation

2. Think about your current living situation.

How do you feel about:

	Terrible	Unhappy	Mostly Dissatisfied	Mixed	Mostly Satisfied	Pleased	Delighted
A. The living arrangements where you live?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
B. The privacy you have there?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
C. The prospect of staying on where you currently live for a long period of time?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Daily Activities & Functioning

3. Think about how you spend your spare time.

How do you feel about:

	Terrible	Unhappy	Mostly Dissatisfied	Mixed	Mostly Satisfied	Pleased	Delighted
A. The way you spend your spare time?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
B. The chance you have to enjoy pleasant or beautiful things?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
C. The amount of fun you have?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
D. The amount of relaxation in your life?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Family

4. In general, how often do you get together with a member of your family?

- ☐ at least once a day ☐ at least once a month ☐ not at all
☐ at least once a week ☐ less than once a month ☐ no family / not applicable

5. How do you feel about:

	Terrible	Unhappy	Mostly Dissatisfied	Mixed	Mostly Satisfied	Pleased	Delighted	Not Applicable
A. The way you and your family act toward each other?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
B. The way things are in general between you and your family?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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CSI County Client Number
Must be entered on EVERY page



Social Relations

6. About how often do you do the following?

- A. Visit with someone who does not live with you?
☐ at least once a day ☐ at least once a month ☐ not at all
☐ at least once a week ☐ less than once a month ☐ not applicable
- B. Spend time with someone you consider more than a friend, like a spouse, a boyfriend or a girlfriend?
☐ at least once a day ☐ at least once a month ☐ not at all
☐ at least once a week ☐ less than once a month ☐ not applicable

7. How do you feel about:	Terrible	Unhappy	Mostly Dissatisfied	Mixed	Mostly Satisfied	Pleased	Delighted	Not Applicable
A. The things you do with other people?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
B. The amount of time you spend with other people?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
C. The people you see socially?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
D. The amount of friendship in your life?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Finances

8. During the past month, did you generally have enough money to cover the following items?

No Yes

- A. Food? ☐ No ☐ Yes
- B. Clothing? ☐ No ☐ Yes
- C. Housing? ☐ No ☐ Yes
- D. Traveling around for things like shopping, medical appointments, or visiting friends and relatives? ☐ No ☐ Yes
- E. Social activities like movies or eating in restaurants? ☐ No ☐ Yes

Legal & Safety

9. In the past MONTH, were you a victim of:

No Yes

- A. Any violent crimes such as assault, rape, mugging or robbery? ☐ No ☐ Yes
- B. Any nonviolent crimes such as burglary, theft of your property or money, or being cheated? ☐ No ☐ Yes

10. In the past MONTH, how many times have you been arrested for any crimes?

☐ No arrests ☐ 1 arrest ☐ 2 arrests ☐ 3 arrests ☐ 4 or more arrests

11. How do you feel about:	Terrible	Unhappy	Mostly Dissatisfied	Mixed	Mostly Satisfied	Pleased	Delighted
A. How safe you are on the streets in your neighborhood?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
B. How safe you are where you live?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
C. The protection you have against being robbed or attacked?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Health

12. How do you feel about:

**Terrible Unhappy Mostly
Dissatisfied Mixed Mostly
Satisfied Pleased Delighted**

- A. Your health in general? ☐ Terrible ☐ Unhappy ☐ Mostly Dissatisfied ☐ Mixed ☐ Mostly Satisfied ☐ Pleased ☐ Delighted
- B. Your physical condition? ☐ Terrible ☐ Unhappy ☐ Mostly Dissatisfied ☐ Mixed ☐ Mostly Satisfied ☐ Pleased ☐ Delighted
- C. Your emotional well-being? ☐ Terrible ☐ Unhappy ☐ Mostly Dissatisfied ☐ Mixed ☐ Mostly Satisfied ☐ Pleased ☐ Delighted

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49283

Please answer the following questions to let us know a little about you.

ENGLISH
Adult Survey

1. What is your gender? ☐ Female ☐ Male ☐ Other
2. Are you of Mexican / Hispanic / Latino origin? ☐ Yes ☐ No ☐ Unknown
3. What is your race? (Please check all that apply.)
☐ White / Caucasian ☐ American Indian / Alaskan Native ☐ Unknown
☐ Black / African American ☐ Native Hawaiian / Other Pacific Islander
☐ Asian ☐ Other
4. What is your date of birth? (Write it in the boxes AND fill in the circles that correspond. See Example.)
Date of Birth (mm-dd-yyyy)
[][] - [][] - [][][][]
0 [][][][][][][][]
1 [][][][][][][][]
2 [][][][][][][][]
3 [][][][][][][][]
4 [][][][][][][][]
5 [][][][][][][][]
6 [][][][][][][][]
7 [][][][][][][][]
8 [][][][][][][][]
9 [][][][][][][][]
- EXAMPLE: Date of birth on April 30, 1967:
1. Write in your date of birth → 04 - 30 - 1967
2. Fill in the corresponding circles
Date of Birth (mm-dd-yyyy)
0 [][][][][][][][]
1 [][][][][][][][]
2 [][][][][][][][]
3 [][][][][][][][]
4 [][][][][][][][]
5 [][][][][][][][]
6 [][][][][][][][]
7 [][][][][][][][]
8 [][][][][][][][]
9 [][][][][][][][]
5. Were the services you received provided in the language you prefer? ☐ Yes ☐ No
6. Was written information (e.g., brochures describing available services, your rights as a consumer, and mental health education materials) available to you in the language you prefer? ☐ Yes ☐ No
7. What was the primary reason you became involved with this program? (Choose one):
☐ I decided to come in on my own.
☐ Someone else recommended that I come in.
☐ I came in against my will.
8. Please identify who helped you complete any part of this survey (Choose all that apply):
☐ I did not need any help. ☐ A professional interviewer helped me.
☐ A mental health advocate / volunteer helped me. ☐ My clinician / case manager helped me.
☐ Another mental health consumer helped me. ☐ A staff member other than my clinician or case manager helped me.
☐ A member of my family helped me. ☐ Someone else helped me. Who?: _____

Thank you for taking the time to answer these questions!

FOR OFFICE USE ONLY:

REQUIRED Information:

County Code:

[][]

Date of Survey Administration:

0 5 - [][] - 2 0 0 5

Reason (if applicable):

Ref ☐ Imp ☐ Lan ☐ Oth ☐

Make sure the same CSI County Client Number is written on all four pages of this survey.

[][][][][][][][][][]

CSI County Client Number
Must be entered on EVERY page

Optional County Questions:

County Question #1 (mark only ONE bubble):

☐ 01 ☐ 02 ☐ 03 ☐ 04 ☐ 05 ☐ 06 ☐ 07 ☐ 08 ☐ 09 ☐ 10
☐ 11 ☐ 12 ☐ 13 ☐ 14 ☐ 15 ☐ 16 ☐ 17 ☐ 18 ☐ 19 ☐ 20

County Question #2 (mark only ONE bubble):

☐ 01 ☐ 02 ☐ 03 ☐ 04 ☐ 05 ☐ 06 ☐ 07 ☐ 08 ☐ 09 ☐ 10
☐ 11 ☐ 12 ☐ 13 ☐ 14 ☐ 15 ☐ 16 ☐ 17 ☐ 18 ☐ 19 ☐ 20

County Question #3 (mark only ONE bubble):

☐ 01 ☐ 02 ☐ 03 ☐ 04 ☐ 05 ☐ 06 ☐ 07 ☐ 08 ☐ 09 ☐ 10
☐ 11 ☐ 12 ☐ 13 ☐ 14 ☐ 15 ☐ 16 ☐ 17 ☐ 18 ☐ 19 ☐ 20

49283



OLDER ADULT SURVEY

Please help our agency make services better by answering some questions. Your answers are confidential and will not influence current or future services you receive. **For each survey item below, please fill in the circle that corresponds to your choice.**

Please fill in the circle completely. EXAMPLE: Correct ● Incorrect ✕ ✓

MHSIP Consumer Survey*:

Please answer the following questions based on the last 6 months OR if you have not received services for 6 months, just give answers based on the services you have received so far. Indicate if you **Strongly Agree, Agree, are Neutral, Disagree, or Strongly Disagree** with each of the statements below. If the question is about something you have not experienced, fill in the circle for **Not Applicable** to indicate that this item does not apply to you.

**START
HERE** →

Approximately, how long have you received services here?

- This is my first visit here. ○ 1 - 2 Months ○ More than 1 year
○ I have had more than one visit but I have ○ 3 - 5 Months
received services for less than one month. ○ 6 months to 1 year

	Strongly Agree	Agree	I am Neutral	Disagree	Strongly Disagree	Not Applicable
1. I like the services that I received here.	○	○	○	○	○	○
2. If I had other choices, I would still get services from this agency.	○	○	○	○	○	○
3. I would recommend this agency to a friend or family member.	○	○	○	○	○	○
4. The location of services was convenient (parking, public transportation, distance, etc.).	○	○	○	○	○	○
5. Staff were willing to see me as often as I felt it was necessary.	○	○	○	○	○	○
6. Staff returned my calls within 24 hours.	○	○	○	○	○	○
7. Services were available at times that were good for me.	○	○	○	○	○	○
8. I was able to get all the services I thought I needed.	○	○	○	○	○	○
9. I was able to see a psychiatrist when I wanted to.	○	○	○	○	○	○
10. Staff here believe that I can grow, change and recover.	○	○	○	○	○	○
11. I felt comfortable asking questions about my treatment and medication.	○	○	○	○	○	○
12. I felt free to complain.	○	○	○	○	○	○
13. I was given information about my rights.	○	○	○	○	○	○
14. Staff encouraged me to take responsibility for how I live my life.	○	○	○	○	○	○
15. Staff told me what side effects to watch out for.	○	○	○	○	○	○
16. Staff respected my wishes about who is, and who is not to be given information about my treatment.	○	○	○	○	○	○
17. I, not staff, decided my treatment goals.	○	○	○	○	○	○

*This survey was developed through a collaborative effort of consumers, the Mental Health Statistics Improvement Program (MHSIP) community, and the Center for Mental Health Services.

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CSI County Client Number
Must be entered on EVERY page

○	-	E	N	0	5	/	0	1	/	0	5
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	Strongly Agree	Agree	I am Neutral	Disagree	Strongly Disagree	Not Applicable
18. Staff were sensitive to my cultural background (race, religion, language, etc.).	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
19. Staff helped me obtain the information I needed so that I could take charge of managing my illness.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
20. I was encouraged to use consumer-run programs (support groups, drop-in centers, crisis phone line, etc.).	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

As a direct result of the services I received:

21. I deal more effectively with daily problems.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
22. I am better able to control my life.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
23. I am better able to deal with crisis.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
24. I am getting along better with my family.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
25. I do better in social situations.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
26. I do better in school and /or work.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
27. My housing situation has improved.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
28. My symptoms are not bothering me as much.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
29. Please provide comments here and /or on the back of this form, if needed. We are interested in both positive and negative feedback.						

Quality of Life Questions:

Please answer each of the following questions by filling in the circle that best describes your experience or how you feel. Please fill in only one circle for each question. For some questions, you may choose **Not Applicable** if the question does not apply to you.

General Life Satisfaction	Terrible	Unhappy	Mostly Dissatisfied	Mixed	Mostly Satisfied	Pleased	Delighted
1. How do you feel about your life in general?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Living Situation

2. Think about your current living situation. How do you feel about:	Terrible	Unhappy	Mostly Dissatisfied	Mixed	Mostly Satisfied	Pleased	Delighted
A. The living arrangements where you live?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
B. The privacy you have there?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
C. The prospect of staying on where you currently live for a long period of time?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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CSI County Client Number
Must be entered on EVERY page



Daily Activities & Functioning

3. Think about how you spend your spare time.

How do you feel about:

	Terrible	Unhappy	Mostly Dissatisfied	Mixed	Mostly Satisfied	Pleased	Delighted
A. The way you spend your spare time?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
B. The chance you have to enjoy pleasant or beautiful things?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
C. The amount of fun you have?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
D. The amount of relaxation in your life?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Family

4. How do you feel about:

	Terrible	Unhappy	Mostly Dissatisfied	Mixed	Mostly Satisfied	Pleased	Delighted	Not Applicable
A. The way you and your family act toward each other?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
B. The way things are in general between you and your family?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Social Relations

5. How do you feel about:

	Terrible	Unhappy	Mostly Dissatisfied	Mixed	Mostly Satisfied	Pleased	Delighted	Not Applicable
A. The things you do with other people?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
B. The amount of time you spend with other people?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
C. The people you see socially?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
D. The amount of friendship in your life?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Legal & Safety

6. In the past MONTH, were you a victim of:

No Yes

A. Any violent crimes such as assault, rape, mugging or robbery?	<input type="radio"/>	<input type="radio"/>
B. Any nonviolent crimes such as burglary, theft of your property or money, or being cheated?	<input type="radio"/>	<input type="radio"/>

7. In the past MONTH, how many times have you been arrested for any crimes?

☐ No arrests ☐ 1 arrest ☐ 2 arrests ☐ 3 arrests ☐ 4 or more arrests

8. How do you feel about:

	Terrible	Unhappy	Mostly Dissatisfied	Mixed	Mostly Satisfied	Pleased	Delighted
A. How safe you are on the streets in your neighborhood?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
B. How safe you are where you live?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
C. The protection you have against being robbed or attacked?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Health

9. In general, would you say your health is:

☐ excellent ☐ very good ☐ good ☐ fair ☐ poor

10. How do you feel about:

	Terrible	Unhappy	Mostly Dissatisfied	Mixed	Mostly Satisfied	Pleased	Delighted
A. Your health in general?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
B. Your physical condition?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
C. Your emotional well-being?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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CSI County Client Number
Must be entered on EVERY page



Please answer the following questions to let us know a little about you.

ENGLISH
Older Adult Survey

1. What is your gender? ☐ Female ☐ Male ☐ Other
2. Are you of Mexican / Hispanic / Latino origin? ☐ Yes ☐ No ☐ Unknown
3. What is your race? (Please check all that apply.)

<input type="radio"/> White / Caucasian	<input type="radio"/> American Indian / Alaskan Native	<input type="radio"/> Unknown
<input type="radio"/> Black / African American	<input type="radio"/> Native Hawaiian / Other Pacific Islander	
<input type="radio"/> Asian	<input type="radio"/> Other	
4. What is your date of birth? (Write it in the boxes AND fill in the circles that correspond. See Example.)

Date of Birth (mm-dd-yyyy)

	[] []		-	[] []		-	[] [] [] []			
0	<input type="radio"/>	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
1	<input type="radio"/>	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2	<input type="radio"/>	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3	<input type="radio"/>	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4	<input type="radio"/>	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
5	<input type="radio"/>	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
6	<input type="radio"/>	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
7	<input type="radio"/>	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
8	<input type="radio"/>	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
9	<input type="radio"/>	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

EXAMPLE: Date of birth on April 30, 1937:

1. Write in your date of birth → **04 - 30 - 1937**

2. Fill in the corresponding circles

	[04]		-	[30]		-	[19][37]			
0	<input checked="" type="radio"/>	<input type="radio"/>		<input type="radio"/>	<input checked="" type="radio"/>		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
1	<input type="radio"/>	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>		<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2	<input type="radio"/>	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3	<input type="radio"/>	<input type="radio"/>		<input checked="" type="radio"/>	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
4	<input checked="" type="radio"/>	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
5	<input type="radio"/>	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
6	<input type="radio"/>	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
7	<input type="radio"/>	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>
8	<input type="radio"/>	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
9	<input type="radio"/>	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>

5. Were the services you received provided in the language you prefer? ☐ Yes ☐ No
6. Was written information (e.g., brochures describing available services, your rights as a consumer, and mental health education materials) available to you in the language you prefer? ☐ Yes ☐ No
7. What was the primary reason you became involved with this program? (Choose one):
 - ☐ I decided to come in on my own.
 - ☐ Someone else recommended that I come in.
 - ☐ I came in against my will.
8. Please identify who helped you complete any part of this survey (Choose all that apply):

<input type="radio"/> I did not need any help.	<input type="radio"/> My clinician / case manager helped me.
<input type="radio"/> A mental health advocate / volunteer helped me.	<input type="radio"/> A staff member other than my clinician or case manager helped me.
<input type="radio"/> Another mental health consumer helped me.	<input type="radio"/> Someone else helped me.
<input type="radio"/> A member of my family helped me.	Who?: _____
<input type="radio"/> A professional interviewer helped me.	

Thank you for taking the time to answer these questions!

FOR OFFICE USE ONLY:

REQUIRED Information:

County Code:

[]	[]
-----	-----

Date of Survey Administration:

[0]	[5]	-	[]	[]	-	[2]	[0]	[0]	[5]
-----	-----	---	-----	-----	---	-----	-----	-----	-----

Reason (if applicable):

Ref ☐ Imp ☐ Lan ☐ Oth ☐

Make sure the same CSI County Client Number is written on all four pages of this survey.

[]	[]	[]	[]	[]	[]	[]	[]	[]	[]
-----	-----	-----	-----	-----	-----	-----	-----	-----	-----

CSI County Client Number
Must be entered on EVERY page

Optional County Questions:

County Question #1 (mark only ONE bubble):

☐ 01 ☐ 02 ☐ 03 ☐ 04 ☐ 05 ☐ 06 ☐ 07 ☐ 08 ☐ 09 ☐ 10
☐ 11 ☐ 12 ☐ 13 ☐ 14 ☐ 15 ☐ 16 ☐ 17 ☐ 18 ☐ 19 ☐ 20

County Question #2 (mark only ONE bubble):

☐ 01 ☐ 02 ☐ 03 ☐ 04 ☐ 05 ☐ 06 ☐ 07 ☐ 08 ☐ 09 ☐ 10
☐ 11 ☐ 12 ☐ 13 ☐ 14 ☐ 15 ☐ 16 ☐ 17 ☐ 18 ☐ 19 ☐ 20

County Question #3 (mark only ONE bubble):

☐ 01 ☐ 02 ☐ 03 ☐ 04 ☐ 05 ☐ 06 ☐ 07 ☐ 08 ☐ 09 ☐ 10
☐ 11 ☐ 12 ☐ 13 ☐ 14 ☐ 15 ☐ 16 ☐ 17 ☐ 18 ☐ 19 ☐ 20

32724



FORM 1: Prioritization and Mapping of Outcome and Performance Areas

OUTCOME AND PERFORMANCE AREAS	PRIORITY			LEVEL OF MEASUREMENT		
	HIGH	HIGHER	HIGHEST	INDIVIDUAL CLIENT	MENTAL HEALTH SYSTEM	PUBLIC / COMMUNITY IMPACT
Meaningful use of time and capabilities						
Employment						
Vocational training						
Education						
Graduation rates for children/youth diagnosed with serious emotional disorders						
Non-public school placement						
Social activities						
Community activities						
Network of supportive relationships						
Adequate housing						
Safe housing						
Safe living environments with family for children and youth						
Reduction in homelessness						
Reduction in out of home placements						
Child welfare status						
Reduction in incarceration in jails						
Reduction in incarceration in juvenile halls						
Reduction in involuntary services						
Reduction in institutionalization						
Hospitalization (long-term restrictive levels of care)						
Hospitalization (acute)						
Timely access to needed help						
Timely access to needed help in times of crisis						

Physical health						
Symptoms/suffering						
Substance use						
Suicide						
Recovery						
Wellness						
Functioning						
Illness self-management						
Individualized service plan goals met						
Income						
Entitlements						
Other: (please specify)						

FORM 2: METHODS OF MEASUREMENT

ATTACHMENT 7

OUTCOME AND PERFORMANCE AREAS (Pick 5 from previous form)	TYPE OF MEASUREMENT <i>Electronic Record</i> <i>Key Event Tracking</i> <i>Survey/Standard Tool</i> <i>Chart Review</i> <i>Special Study</i> <i>Database Linking</i>						PROVIDE A SHORT DEFINITION OR DESCRIPTION OF THE MEASURE.	HOW OFTEN SHOULD MEASUREMENT TAKE PLACE?